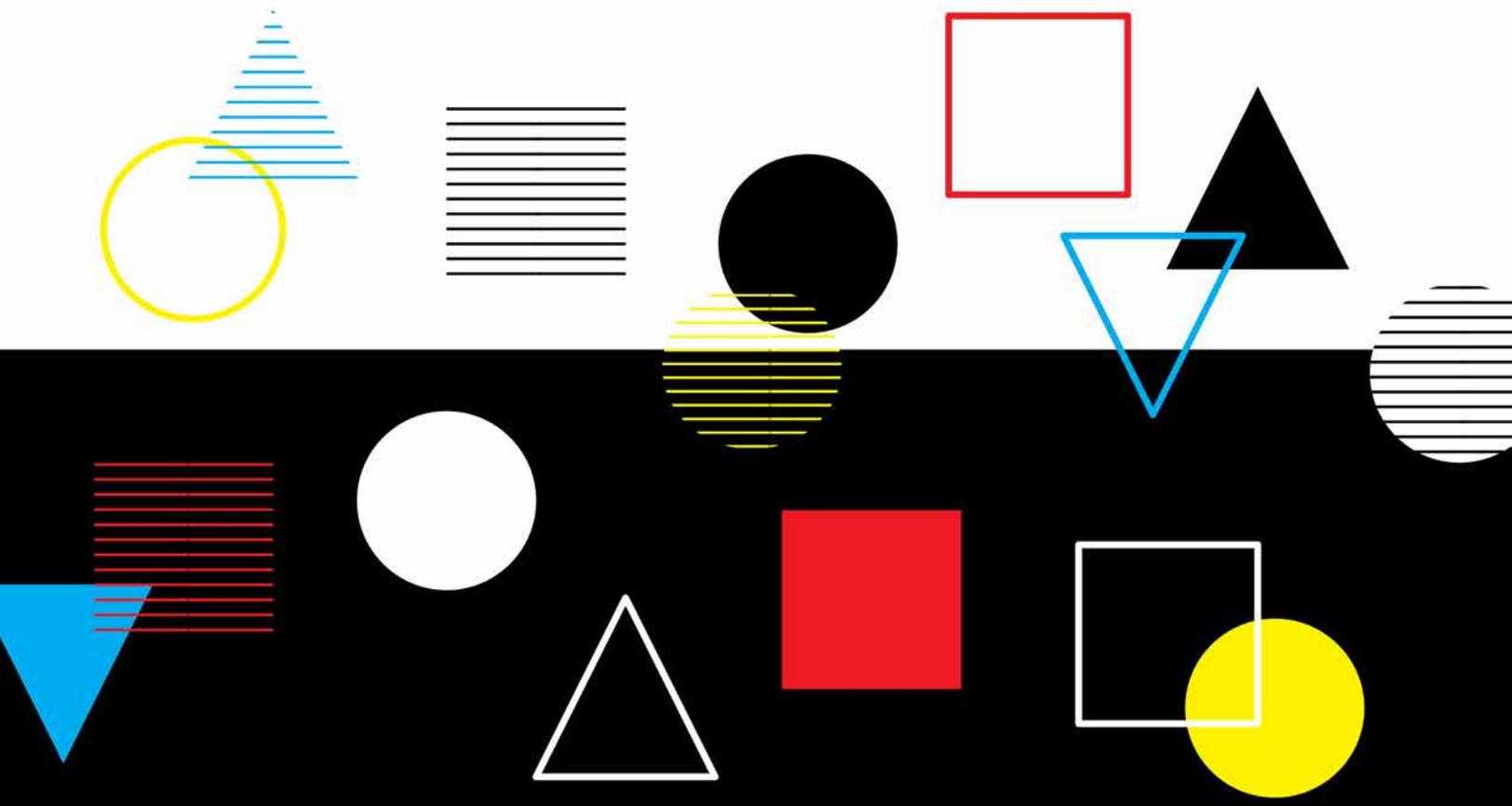


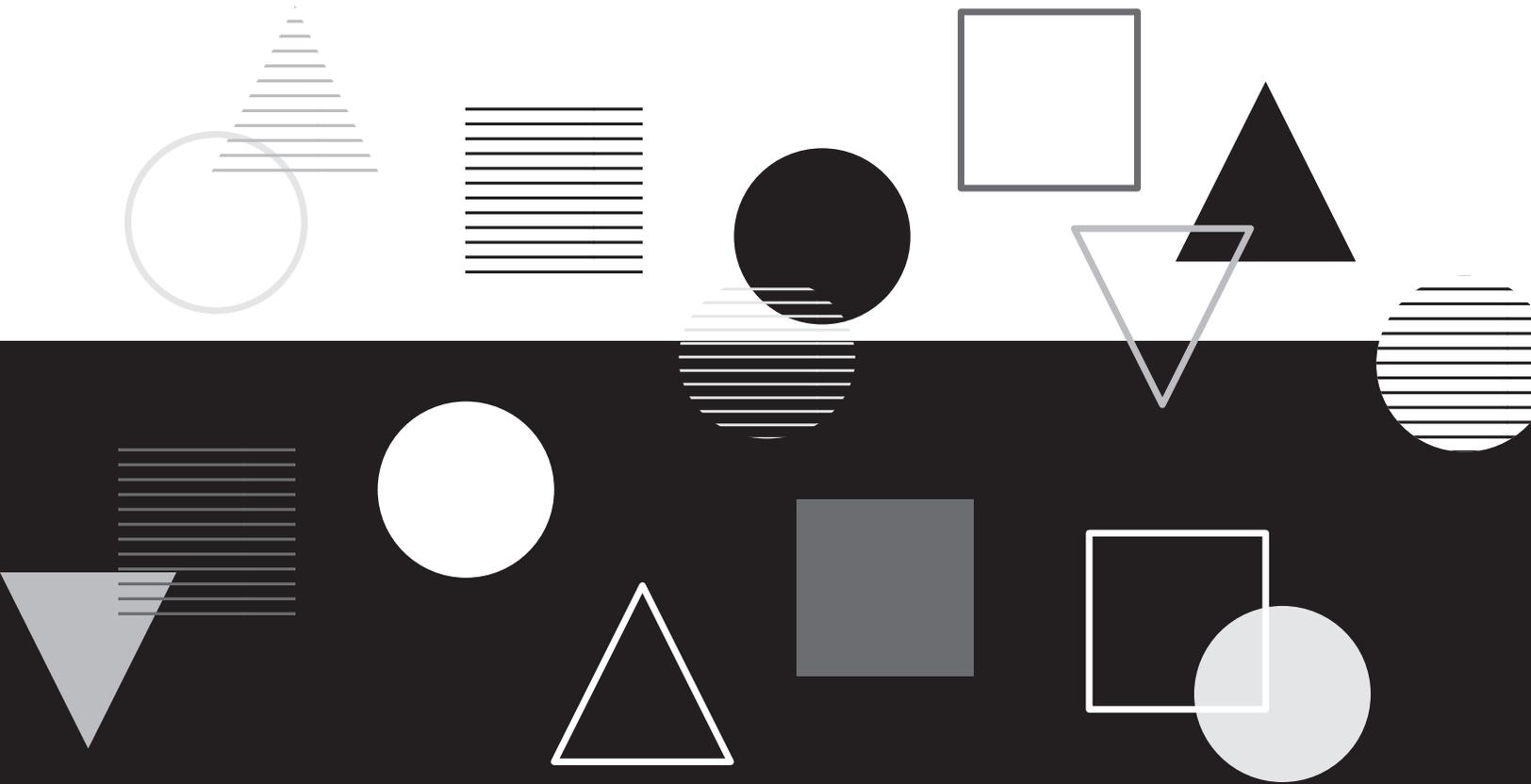
# INCLUDING ALL CHILDREN



Transitioning to an Inclusive  
Early Learning Program

Sarah Taylor Vanover, EdD

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## Transitioning to an Inclusive Early Learning Program

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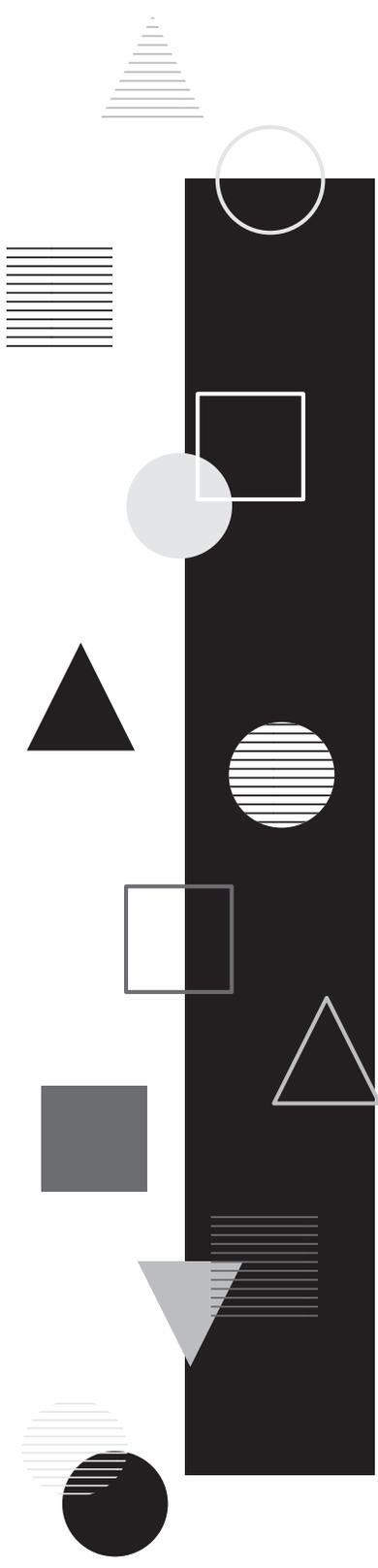
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## **DEDICATION**

This book is dedicated to Rebecca Hill, Marissa Cupp, Jasmine Jones, Dr. Jeremy Warner, Dr. Susan Slade, and all the amazing professionals who have been a member of my son's support team. I am so thankful for each pediatric expert who has supported him so that he can be successful in an inclusive classroom.



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## PREFACE: MY STORY

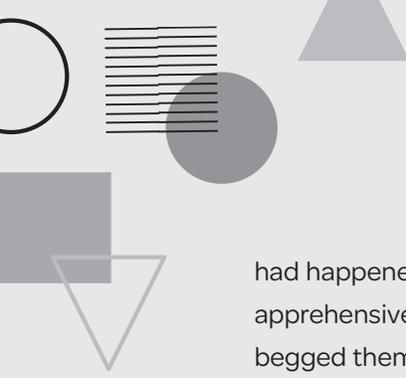
When I was a child, I knew what disabilities were, but they were so far removed from my world that they seemed unrealistic. My family was healthy, and we seemed to lead a relatively normal life. Unfortunately, that track record ended in high school.

At the beginning of my sophomore year, I began having fainting spells. The pediatrician attributed them to low blood sugar and told me that I needed to have four to six small meals throughout the day to keep my blood sugar levels higher and more consistent. Then one day in choir, I stood up to join a small group of singers in the hallway and fainted, falling down the choir risers. I woke up confused while EMTs secured me to a gurney and took me to the emergency room. There, the doctor thought that it was time I see a specialist, and she connected my parents with a pediatric endocrinologist at a large hospital two hours away from my hometown. We spent a week in the hospital, and at the end of our visit, the doctor determined that severe drops in my blood sugar were causing me to lose consciousness. The doctor put me on a diabetic diet, told me to check my blood sugar three to five times a day, and scheduled follow-up visits every two months.

I tried to eat what I was supposed to eat, but I was fifteen years old and didn't understand the full impact of ignoring a doctor's orders. There were times that I indulged in milkshakes and candy bars, but that usually came with consequences. Eating something with lots of sugar would rebound and make my blood sugar crash again. When I became dizzy or passed out, I would promise that I wouldn't ignore my diet again. Of course, there were always mistakes, but they happened less often as the months went on and I battled against my sweet tooth.

I was an active teenager, and I always had places to be. I was really involved in my school choir and at my church. In the spring of my junior year of high school, I arrived at church early one Sunday so that I could prepare to lead worship in our church service. While singing in the service that morning, I had a grand mal seizure in front of the entire congregation. Although sixteen-year-old girls tend to thrive on attention, this was not the type of attention I wanted. I woke up in the ambulance on the way to the hospital and had no memory of what had occurred at church. Tests showed that there was enough electrical activity to indicate that I did indeed have a seizure. The doctor told me that one seizure did not mean that I had a seizure disorder, but it did mean that the doctor needed to watch me closely. It also meant that I could not drive for the next ninety days due to state law.

Three months later, I was at a summer music camp in Santa Barbara, California, and I had a second grand mal seizure. Once again, I did not remember anything that



had happened, but this time I was a long way from home. My parents had been so apprehensive about letting me go to camp after the first seizure occurred, but I had begged them to let me go because my health had been fine. The day after the seizure, I flew home to Kentucky, and my mom was already working on finding a pediatric neurologist who could help us understand what was going on. This time I ended up at Washington University Hospital in St. Louis, Missouri, where, after a long week of lots of tests, the pediatric neurologist diagnosed epilepsy.

Before we left, the doctor started me on the first of many anti-convulsant medications I would take in my lifetime. Throughout my senior year and most of college, I struggled with remembering to take my medication, avoiding caffeine, and getting enough sleep. Stress was also a major trigger for my seizures. In college, you could almost track my seizures around midterms and finals, when I was stressed and sleep deprived. Each time it happened, I lost my driver's license. As a young adult, that was the part that upset me the most. Of course, I had friends who would take me places when I needed them to, but the loss of my independence was the frustrating part. My illness also came with many doctor visits and a lot of medication side effects. During the first four years of my diagnosis, I must have tried at least five different seizure medications. It took a long time to find the right medication, and then the doctor had to find the right dosage.

While I was worried about my medication, my parents were trying to find a way to cover the cost of the doctor visits, the tests, the MRIs, and the medication. We were blessed to have good health insurance, but it didn't cover all the expenses that I was collecting. My mom became an expert at fighting with health insurance companies. Before I went to college, we took one trip to campus just to find a neurologist who was close enough for me to visit for regular medical care. We looked for a pharmacy where I could get my medication. My father switched jobs while I was in college, and we had to prove that I did not have a breach in medical coverage to keep getting treatment for my pre-existing condition. When you looked at me, you couldn't notice anything visibly wrong, but my diagnosis was starting to be a huge part of my life.

I have spent a large portion of my life trying to live as if I don't have a disability. I pursued higher education through my doctorate degree, regardless of the stress and hours of study that it included. I had two healthy children, even though I was a high-risk pregnancy each time, which required quite a few extra doctor appointments. Many times, I have taken on too much work and responsibility, and I wonder sometimes if I am just trying to prove that I can do anything that a "normal" person can do. In the end, a high stress load always comes back to haunt me. The only way to really live with, and even overcome, my disability is to take care of myself and admit when something is just too much for me.

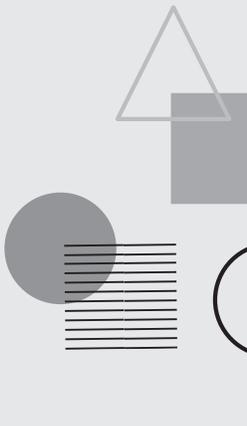
While I was in college, I decided that I wanted to major in early childhood education. I had always wanted to do something with young children. At first, I think I was a little more interested in what it “looked like” to be a preschool teacher. I loved their colorful classrooms with the alphabet and shapes displayed on the walls. I loved watching teachers read dramatic stories to the children and sing silly songs while the children danced around on the carpet. It seemed like an inconvenience when the teacher had to spend time dealing with the children’s negative behaviors, but because I was observing veteran teachers, they always seemed to handle the situation so effortlessly.

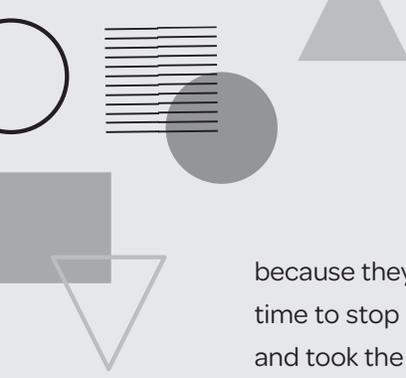
As I got closer to graduating and pursuing my teacher’s certificate, I began thinking about the type of classroom in which I wanted to work. In early childhood education, I could go into a traditional play-based preschool classroom or a classroom that also supported children with special needs. At that point in my career, those two options seemed completely separate: a “normal” classroom or a classroom that had children with disabilities. It seemed more fun to get a job in a traditional preschool classroom where I could do curriculum units on farm animals and community helpers. I would be able to have all the children in my classroom sit at circle time at once and read *Harry, the Dirty Dog* or *The Very Hungry Caterpillar* to them. I envisioned all the children being able to do the same activities and participate together.

My first teaching job was in a private school that served children in the three-year-old preschool through sixth grade. It was a beautiful campus filled with well-organized classrooms and teachers who had worked with young children for years. I was in a blended classroom that had three-, four-, and five-year-old students, and I had two co-teachers.

The week before the school year started, at open house, I met Jacob and his family. Jacob was an incoming three-year-old child. His mother and father both attended the open house, but his father was preparing to leave the country for the next three weeks. The family was in the middle of an international adoption, and Mr. Ralph was going to travel to Asia to pick up their newborn baby girl while Mrs. Ralph stayed at home with Jacob.

The new school year started, and Jacob arrived on the first day wearing a backpack that was almost bigger than his whole body. Just like several of the other three-year-olds, he was apprehensive of his new surroundings and scared to leave his mother. On the first day, Jacob had two bathroom accidents that were very messy. I cleaned him up and put clean clothes on him. I communicated with his mother to let her know what had happened. My co-teacher, who had taught at the school for twelve years, told Mrs. Ralph that it wasn’t unusual for children to have accidents on the first couple of days of school





because they are so interested in the new classroom that they don't want to take the time to stop playing and go use the restroom. Mrs. Ralph seemed fine with the situation and took the setback in stride. Unfortunately, Jacob's accidents didn't just happen for a few days; they became a consistent pattern. Because I was the primary caregiver for the three-year-olds, I grew accustomed to helping Jacob clean up and continue with his school day. I had worked in a child-care program before being hired at this new school, so I was familiar with helping students through the potty-training process.

A couple of weeks later, Jacob had another accident, but I had left the room. One of my co-teachers had to help Jacob clean up, and it was apparent at that point that my co-teachers had a very different idea of what was appropriate for a preschool classroom compared to my interpretation. That afternoon, my co-teachers asked Mrs. Ralph to come in for a conference. Mr. Ralph was still in Asia, and he would not return for four more days. With the support of the school principal, my co-teachers told Mrs. Ralph that Jacob was not developmentally ready to start preschool. They suggested that she find a different child-care program and possibly apply again next year for our school. At that moment, Mrs. Ralph was alone as she received the overwhelming news. She worked outside of the home, but she no longer had child care. The school did not acknowledge the potential trauma that Jacob may have been experiencing while his father was away or as he processed the knowledge that he had a baby sister coming. No accommodations were made. They simply told the family that Jacob was not a good fit for the school.

As I sat back and watched this situation evolve, I was overwhelmed by the whole situation. This was my first teaching position after receiving my teacher's certificate, and I didn't know if this was a typical situation. I thought I was in a "normal" classroom, so it seemed odd that a child was not toilet trained at three years old. But I had previously worked with four-year-old children with whom the problem didn't really come up. I convinced myself that the situation was a fluke and tried to go back to my "typical" school year.

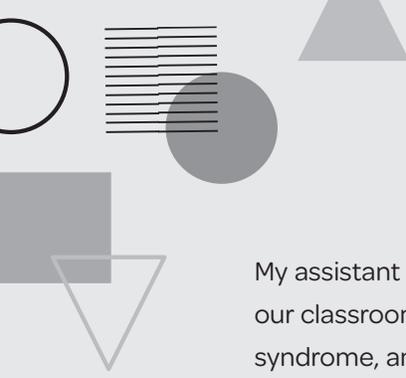
Later that year I started to notice some strange behaviors from one of the other three-year-old children in my group. Everett was one of my youngest students, and he was smaller than any other child in the classroom. He seemed like he walked around the classroom in a fog most of the time. When he tried to pick up the classroom materials, it was a challenge for him to carry them to a table because he was so small. Often when Everett was walking around the room, he would slow to a stop and just stare off into space. I would have to call out his name and get his attention to redirect him. He had also begun to wet his pants at least once a day. This was odd because he had been completely toilet trained with no accidents and then seemed to suddenly regress. My

child-development background had taught me that you could not diagnose children with attention-deficit disorder until they are much older than three, but it seemed that he was constantly distracted.

As I spent more time with Everett, I began to realize that he did not realize that he was staring off into space. When I was finally able to get his attention, he often seemed to have forgotten where he was. I noticed this same type of behavior when he had a bathroom accident. I was the one who told him that his pants were wet, and he had no recollection of why he had not gone to the restroom. With my own personal history of epilepsy, these symptoms sounded familiar to me. I talked to my co-teachers and discussed calling the parents to let them know the symptoms we were seeing in the classroom: blank stares, confusion, incontinence, and small losses of time. We recommended that the family take Everett to his pediatrician to discuss his symptoms. Two months later, Everett was at the neurologist getting evaluated for absence seizures. When my co-teachers learned about Everett's diagnosis, they were instantly uncomfortable with caring for a child with special health-care needs. I did not have any medical training, but I had been learning for years about how to support someone with epilepsy. I immediately let the principal know that I felt completely comfortable caring for Everett, and I just needed a conference with his parents to see how his doctor planned to treat his condition. My principal agreed.

This preschool program was supposed to serve "typical" students. They interviewed each family in advance and admitted the children who seemed the most capable to thrive in a structured preschool program. Despite the school's efforts, there were still children in the program who needed accommodations and additional support. I noticed very quickly that the school was not set up to offer that support, and because of that, students like Jacob were told to find a program that could better meet their needs. The whole family was affected when the school could not support a child enrolled in the program. I also realized that it wasn't the children who needed to change; it was the school. The teachers needed more training on how to work with children with disabilities or special health-care needs. The classroom materials needed to accommodate a wider range of skills so that children of different ability levels could play.

After two years of teaching at the private preschool, my interests had changed. I applied for a position with a local school system as an early childhood special-education teacher. I wanted to work with the children my previous school could not support. I accepted a preschool teacher position for a classroom of students with disabilities and students who were considered "at risk" due to living at the poverty level. By the second week of school, I had seventeen children in my classroom, and sixteen of those children were diagnosed with disabilities.



My assistant teacher and I were completely overwhelmed. Several of the children in our classroom had significant disabilities, such as autism, cerebral palsy, fetal alcohol syndrome, and cognitive delays. The other students in the classroom had milder conditions but still suffered from some type of delay. There were no typically developing children in the classroom to serve as role models, and the children in our room seemed separated from the rest of the school. Although I was supporting the children whom I wanted to help, I was overwhelmed and didn't feel like I was accomplishing anything. The students needed so much more support than I felt I could offer, and it didn't seem as though I could spend enough individual time with each child.

In short, this classroom setting didn't seem to be right either. Students with disabilities needed a preschool setting that gave them proper support, but totally isolating them made the workload overwhelming for the teachers and didn't give the children enough room to grow. The K-12 education system already had made great strides in setting up inclusive classrooms and placing children in the least restrictive environment (LRE). They had moved away from isolating children in special-education classrooms and were allowing them to stay in the typical classroom setting as much as possible. It baffled me that the birth-to-five education system seemed to be miles behind.

The root of this problem is that most children between the ages of infancy and kindergarten are eligible to be cared for in private child-care programs that are independent small businesses. Unlike the K-12 school system, they do not receive special-education funding to pay for additional staff members, training, and modified materials that children with disabilities may need. Children qualify for the public school system when they have a diagnosed disability, so many of those children naturally find a special-education preschool classroom. What needs to happen for the early education community is to find a way to blend these two environments to care for all types of children in inclusive classrooms.

Fast forward nine years, when I was pregnant with my second child, I felt like I had a soccer player inside my belly. He moved and kicked every few minutes, day or night. When he was finally born, he did not calm down. He was diagnosed with colic by the time he was five weeks old, and he spent more than two-thirds of his waking hours screaming at the top of his lungs. He was feisty from the beginning.

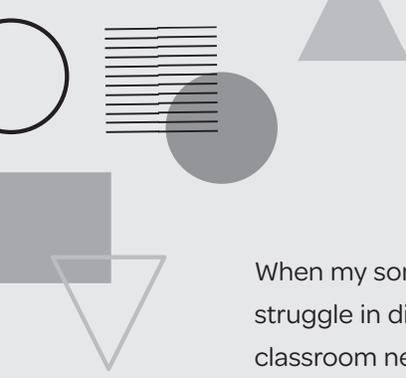
With his great desire to move, he was up and moving every single night. He didn't sleep through the night for the first time until he turned thirteen months old. He became very attached to me and wouldn't let anyone else feed him. In fact, he wouldn't drink from a bottle at all; he would only breastfeed. When we tried to introduce baby food and eventually table food, it was a struggle. Luckily, I was working as the executive

director of a private, nonprofit, inclusive child-care program at the time, and the amazing occupational therapist on staff was giving me tips to help ease him through this transition.

Because he was always on the move, he crawled and walked ahead of developmental norms. My husband sang to him every night, and I read him books. We were constantly talking to him and his big brother, even when he couldn't respond to us yet. Because of hearing so much language at a young age, he was an early talker, and by age two he had a huge vocabulary. You could tell that he was smart because of his vocabulary and because he was a problem-solver. He would work through frustrations with his toys on his own and never let difficulties slow him down. Not only was he smart, but he was also stubborn.

I don't want to make stubborn sound like a bad thing. My son had an iron will at a very young age. When he made up his mind to do something, he was determined and steadfast. This determination could be positive or negative. He could be determined to complete a puzzle or he could be determined not to eat his dinner. He would refuse to speak to people that he did not know, and even if they tried to wear him down, he would not speak to them. When my son switched to his first preschool classroom, we enrolled him in a private, employee-based child-care program. After he initially started at the school, it took him almost three months before he would speak to the teacher. When he finally did talk to her, she was ecstatic! Sometimes, a teacher who did not know him might try to make him do something such as eat all of his lunch or go to sleep at naptime. That was like someone throwing down a gauntlet, and James was going to rise to the occasion. Nothing was more important to him than being right or doing something the right way (as he saw it).

He was content to play at school. He loved to play with dress-up clothes, color pictures, and do puzzles, but he often did these activities alone. He was a reserved child and did not like to be around the noisy, outgoing children. He would find a quieter place in the classroom and play contentedly, usually beside another quiet child. Because he went to a high-quality preschool program, the school gave him some flexibility. If it was too overwhelming for him to sit at circle time with the other children, then the teachers let him quietly play in the back of the classroom. He usually heard all of the songs and the calendar, but he didn't have to be overwhelmed by the large group of children. Instead of forcing him to do one particular activity, the teachers tried to give him choices so that he felt more in control. Also, he had wise teachers who decided to pick their battles and only insist on his compliance when it came to a safety issue.



When my son started kindergarten at our public elementary school, I began to see him struggle in different ways. The school day was structured and fast-paced. If the whole classroom needed to move on to the next activity before he finished his work, then he would be overwhelmed by the transition. Activities such as circle time were hard for him to participate in, and they caused him to panic. Usually that panic led to a fight-or-flight reaction. At school, he would usually hide under a desk or in the corner of the classroom when he was overwhelmed by the pace of the day or was scared by not knowing what was coming next. At home, where he was most comfortable, that panic would often result in yelling and hitting. He did not want any type of social attention, so activities such as morning greetings could cause him anxiety hours before he arrived at school. Fun days, like Crazy Sock Day, meant that children would be staring at him all day to see what socks he had on, and that also caused stress.

The kindergarten teacher called me on the first day of school and asked me about strategies that we use at home to help him be successful. It's never a good sign when the teacher calls you on the first day. My husband kept asking me, "Should we be worried yet?" I was telling him that our child was smart, stubborn, and shy. We just needed to watch him grow and see if he moved through some of these phases. During this period I started to notice that, although his vocabulary was huge, he didn't always use his speech in the socially correct way. Other children his age were starting to make jokes that easily offended him. He would say things that seemed extremely rude, but he seemed to think he was being helpful. He seemed to insult me frequently, and as a mom, that was hard to take. I asked the school for a speech evaluation to look at the way that he used his vocabulary because it just seemed off. The school said he passed his speech evaluation with flying colors, and he graduated from kindergarten with a lot of unanswered questions.

The next year in first grade was much more challenging. The emotional meltdowns were occurring all the time. At home they became violent, but at school, he hid and couldn't regroup for the remainder of the school day. As he became more and more aggressive with me and my older son, I told my husband that it was time to get help. I thought maybe he was showing signs of oppositional defiant disorder, since he was so stubborn and rigid. Once we finally found a counselor who was willing to see a six-year-old, she felt she was seeing signs of significant anxiety and possible autism spectrum disorder. Looking back, that is the point that I had to become an advocate for my child. I started an uphill battle that day.

I began looking for specialists who could evaluate my child for autism. I called universities and private physician practices. Before they could agree to make an appointment, I needed to fill out dozens of forms and screening tools to see if he

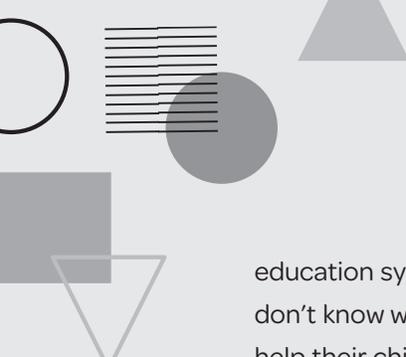
qualified for an evaluation. Once I had taken off the rose-colored glasses of being his mother and tried to see him from the viewpoint of a professional, I realized that he had a lot of the criteria that the diagnosticians were looking for before consenting to an evaluation. I was calling so many specialists to try and get him on at least one waiting list, and they all had different forms. I decided to make one log of all the symptoms and concerns that I had noticed since he was an infant. I kept a running Word document that I added to over time, and I printed it off for each new doctor that we met with.

As someone with a background in special education, I was lucky that I knew a lot of therapists and specialists in the field. I had never asked for favors from anyone before, but now I was trying to help my son and would do anything I could to support him. I had reached out to a pediatric occupational therapist whom I had worked with before to ask her to start seeing my son. She said that it would be six months before she would have an opening in her schedule, but she was willing to call a child psychiatrist she knew to ask her to fit my son into her busy schedule. Then, I had to find an occupational therapist to see him, and after all the money I had spent on autism evaluations, second opinions, and psychiatric evaluations, I had to find a practice that would take my health insurance.

When I talked to my pediatrician about my son, he still couldn't believe the autism diagnosis. My son didn't fit the textbook case of a nonverbal boy who was obsessed with trains. Instead, he was a seven-year-old with an IQ of 140 who had a challenging time dealing with transitions and changes to routines. I would tell people close to me that he was diagnosed with autism, and they would say, "He doesn't look like he has autism." Even when a close friend or family member would say something so foolish, I wanted to respond by saying something like, "Well, we parted his hair on the left today, so that's why you can't tell."

My fight for my son started by getting his diagnosis and the best medical care possible, but my fight continues when it comes to getting him the best possible education. Because he has a high IQ, the school doesn't always agree that his disability is affecting his schoolwork, which is the whole purpose of special education. Instead, I must prove to the school system every year that his emotional meltdowns at school and his intense anxiety limit his ability to be successful. I have to show them that he needs accommodations such as movement breaks during the day and advance notification of changes to his school routine.

Being the parent of a child with a disability is challenging. Daily, I may have to fight the health insurance company, the school system, and the director of the local gymnastics classes just to let him have normal childhood experiences. I have started this battle with resources that many families don't have and with a strong knowledge of the special-



education system. I just don't understand how families can navigate this situation if they don't know who to turn to and what their child needs. Every family deserves the right to help their children be successful.



My experiences have shaped me as an individual with a disability, as a teacher, and as a mother. My perspective on special education has been created by all three points of view. As an adult living with a disability (epilepsy), I understand how hard it may be to overcome stereotypes, take care of yourself properly, and live in a world where others don't understand your limitations. As an early childhood teacher, I've seen children who desperately needed a classroom and an education system that would support them no matter what their ability level was. As a parent of a child with autism, I learned a deep empathy for children with disabilities and their families, empathy that I did not understand as a young teacher or an administrator. I now have a passion for inclusive early childhood education, which is the driving force in my career and what propelled me to write this book.



## CHAPTER 1

# Defining Inclusion

The need for inclusive child care in the United States is overwhelming. The US Census Bureau indicates that more than three million children had a diagnosed disability in 2019, which was approximately 4.3 percent of the total child population. The Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA) state that 17 percent of children between the ages of three and seventeen have a developmental delay and need assistance to catch up to the normal developmental milestones (2022). This means that one in six children needs additional educational support to be successful (Young and Crankshaw, 2021). The CDC and HRSA (2022) also found that the following groups were more likely to have a developmental delay than others:

- Boys had a greater chance of a delay than girls.
- Non-Hispanic children (both Black and White) were more likely to have a diagnosed delay than Hispanic children.
- Children in rural areas had a greater chance of a diagnosis compared to children living in urban areas.
- Children on public health insurance were more likely to have a developmental delay than children on private health insurance or children who are uninsured.

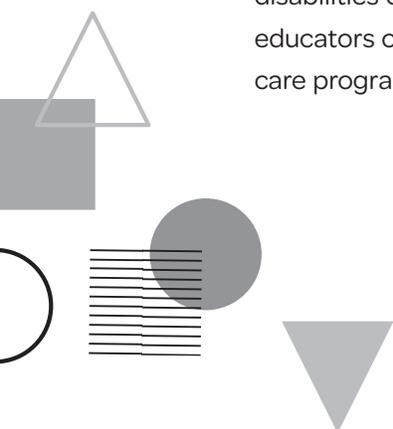
There is a difference between a disability and a developmental delay. *Developmental delay* is a term used when a child is behind the typical timeline for meeting developmental milestones. If a young child receives therapeutic support for a developmental delay in a timely fashion, then the child may not have a permanent developmental delay. Most schools will try to use the term *developmental delay* until the child turns eight years

of age to see if the diagnosis is temporary. The term *disability* is a more permanent diagnosis. It is typically related to a medical diagnosis that affects a child's mental and physical development.

Early intervention and inclusive preschool services have been accessible throughout the United States for years; however, the COVID-19 pandemic affected many children's ability to access those services (Shapiro and Bassok, 2022). Early education classrooms had to suspend in-person classroom time. The core principles of child development are focused on children learning by exploring the environment through their senses. When young children are limited to watching a screen for learning, many of those key learning skills are limited (Shapiro and Bassok, 2022).

Many families dropped out of virtual preschool programs because they saw their children's lack of interest. Plus, one of the foundational skills of preschool is social and emotional learning with a group of peers, and peer interaction was not possible on a computer screen. Children could see their peers and talk to them, but they could not learn to share or engage in group play. Once classrooms resumed in-person learning, it was obvious that many children were not at the developmental level that is typically expected in their age range. With early interventions, most toddlers and young preschoolers could not show more than a few minutes of interest in a computer screen, much less complete an activity with the therapist. Therefore, children who were already diagnosed with a developmental delay or a disability prior to the pandemic rarely made developmental strides during this period, and most saw developmental losses (Shapiro and Bassok, 2022).

As a society, our goal should be to establish a seamless education system that supports **all** children, beginning in the infant room. We cannot wait until a child starts kindergarten to provide an inclusive environment. Many child-care programs do not know what they need to do to support more families of children with disabilities. They do not understand what policies need to be in place to accommodate children with disabilities or special health-care needs. This book is a guide to help early childhood educators care for all children, regardless of ability level, by creating an inclusive child-care program.



## ABOUT THIS BOOK

If you are reading this book, you're probably interested in creating an inclusive learning environment but are unsure of how to go about it. Perhaps you're not sure if your teaching staff and the families you serve understand why offering an inclusive program is important. Perhaps you are concerned about the changes you'll need to make to your classroom environment, materials, and curriculum. Or perhaps you are just beginning to delve into inclusive child-care programs and want to have a sense of where to begin. This book will help you answer your questions, alleviate your concerns, remove roadblocks, and get you on your way.

This first chapter provides an introductory discussion about inclusive child-care programs: what it means to be inclusive and why it is beneficial. Chapter 2 describes the different laws surrounding special education. Building on this background, chapter 3 delves into the first step in creating an inclusive child-care program: drafting a vision and mission statement to reflect your program's approach. Chapter 4 provides an overview of how you might start the transition, and chapters 5 and 6 get into the nitty-gritty of becoming an inclusive child-care program: setting policies and creating accommodations to support children with disabilities and their families. The final two chapters of this book discuss supporting staff in the inclusive classroom and collaborating with families and the community.

Interspersed throughout the chapters are personal perspectives from a parent of a child with disabilities, an early childhood director, a child-care provider, and a pediatric occupational therapist. These personal perspectives are included to show real-life examples of what families and professionals see when they enter inclusive and noninclusive classrooms. Their examples show how the inclusive environment benefits all the enrolled children in the classroom, not just those identified with developmental delays. They also show how the family and the teachers can have positive experiences by looking at a more individualized approach to education.

The first story shows the perspective of a family who desperately needed an inclusive child-care setting for their foster children. The children were turned away from other programs, and they needed the support that only an inclusive program could offer. The second story is from the perspective of a director who administers an inclusive child-care program. She has had the opportunity to see so many successes for children struggling with their delays, and she has gotten to watch those children grow and develop over time with supportive services. An early interventionist gives her perspective on inclusive child care after going into hundreds of child-care classrooms in her career, and a veteran early childhood educator who has worked in both inclusive and

## Create a truly inclusive early learning program that supports every child, regardless of their ability level.

Creating an inclusive early learning program can be a challenge for site leaders who lack knowledge about special-education laws, struggle to create policies and accommodations that meet the needs of all children, and find it difficult to support staff and collaborate with families and the community.

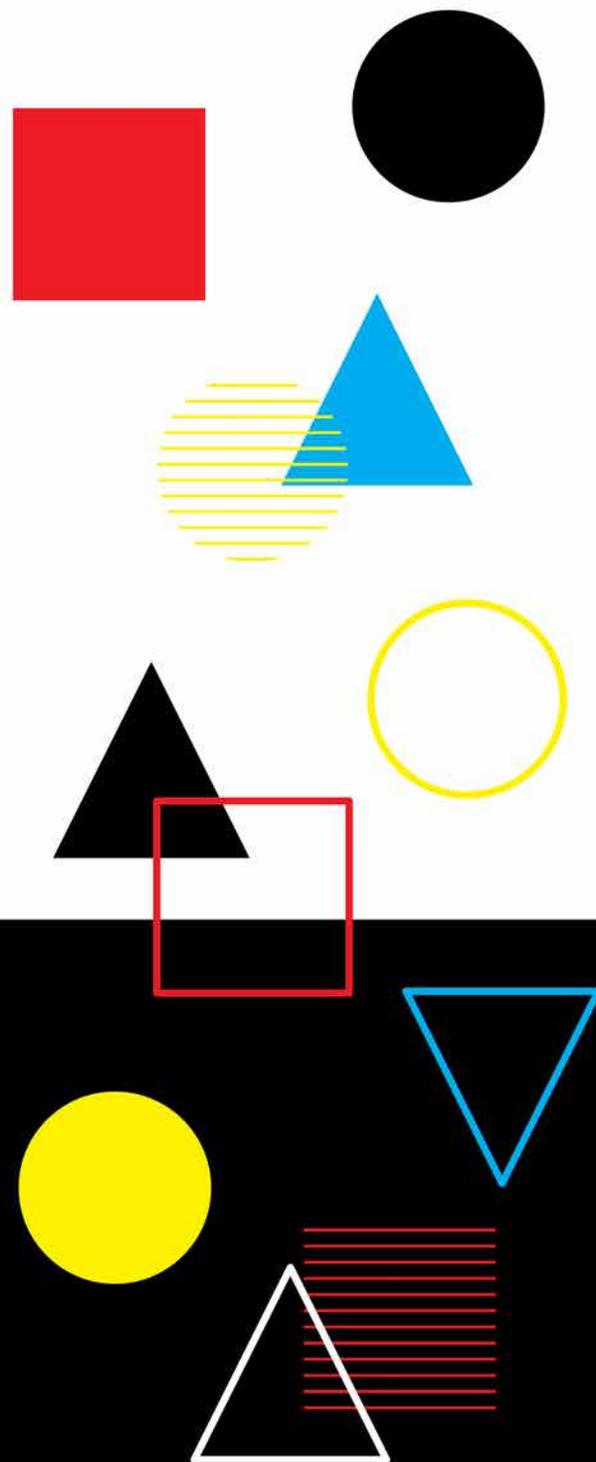
With its step-by-step approach, real-life examples, and expert perspectives, ***Including All Children: Transitioning to an Inclusive Early Learning Program*** provides everything site leaders need to make their programs truly inclusive. You'll learn how to draft a powerful vision and mission statement, navigate the legal landscape of special education, and create policies and accommodations that meet the needs of children with disabilities and their families.

- Gain a deeper understanding of special-education laws.
- Learn how to create policies and accommodations that meet the needs of all children.
- Discover how to support staff and collaborate with families and the community.
- Create a truly inclusive environment that benefits every child.

With personal perspectives from experts in the field, ***Including All Children*** offers a unique and insightful perspective on how to create a truly inclusive environment. Whether you're a site leader, an educator, or a parent, this book is the ultimate resource for anyone who wants to make a real difference in the lives of children.



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